Pertussis Contact Investigation Worksheet

Case Name:_	

Contact Information	Demographics	Relationship to Case	Symptoms		Treatment/Prophy Recommendations	Immunization History* *Document only medically verified pertussis vaccine, (i.e., school
					Recommendations	records, immunization card, health care provider records.
						Parent/guardian verbal report is not a medically verified report).
						DTaP/ Tdap Immunization and Date
						Dose 1
Name:	DOB: / /	Household □	Cold symptoms	Y N	Azithromycin	Dose 2
Phone:		Other □	Cough. Onset date//_		Other:	Dose 3
Address	Race:	(Specify)	Cough for 2 wks or more		Start Date://	Dose 4
City:	Ethnicity:	Infants <1 yr. in home Y□N□	Paroxysm	Y N		Dose 5
State:			Whoop	$Y \square N \square$	N/A □	Dose 6
		PG female in home Y□N□	Vomiting	Y N		DTaP/ Tdap Immunization and Date
Name:	DOB://	Household □	Cold symptoms	YD ND	Azithromycin	Dose 1
Phone:	Male□ Female□	Other 🗆	Cough. Onset date//	$Y \square N \square$		Dose 2
Address	Race:	(Specify)	Cough for 2 wks or more	$Y \square N \square$	Start Date://	Dose 3
City:	Ethnicity:		Paroxysm	$Y \square N \square$		Dose 4
State:		Infants <1 yr. in home Y□N□	Whoop	$Y \square N \square$	N/A □	Dose 5
			Vomiting	Y N		Dose 6
		PG female in home Y□N□				DTaP/ Tdap Immunization and Date
	DOB://	Household □	Cold symptoms		Azithromycin	Dose 1
Phone:		Other 🗆	Cough. Onset date//	Y N		Dose 2
Address	Race:	(Specify)	Cough for 2 wks or more		Start Date://	Dose 3
City:	Ethnicity:	Infants <1 yr. in home Y□N□	Paroxysm	Y N		Dose 4
State:			Whoop	Y NO	N/A □	Dose 5
		PG female in home Y□N□	Vomiting	Y N		Dose 6
						DTaP/ Tdap Immunization and Date
Name:	DOB://	Household □	Cold symptoms		Azithromycin	Dose 1
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Address	Race:	(Specify)	Cough for 2 wks or more		Start Date://	Dose 3
City:	Ethnicity:	Infants <1 yr. in home Y□N□	Paroxysm	Y N		Dose 4
State:			Whoop	YD ND	N/A □	Dose 5
		PG female in home Y□N□	Vomiting	YD ND		Dose 6
						DTaP/ Tdap Immunization and Date
	DOB://	Household □	Cold symptoms		Azithromycin	Dose 1
Phone:	Male□ Female□	Other 🗆	Cough. Onset date//	Y N		Dose 2
Address	Race:	(Specify)	Cough for 2 wks or more		Start Date://	Dose 3
City:	Ethnicity:	Infants <1 yr. in home Y□N□	Paroxysm	Y N		Dose 4
State:			Whoop	Y N	N/A □	Dose 5
		PG female in home Y□N□	Vomiting	Y N		Dose 6

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